125 CAFETERIA PLAN EMPLOYEE ELECTION FORM

All information in this section is required to be completed.

Employer Name:	Plan Year: MM/DD/YYYY-MM/DD/YYYY
Employee Name:	Social Security Number:
Address:	City, State, Zip:

Date of Birth:	Date of Hire:	Gender:

Email Address:	Mobile Phone Number*:

**** Mobile Phone is required to validate secure access to your online portal via SMS Text for submitting claims.***

FLEXIBLE SPENDING ACCOUNT (FSA)

I elect to participate. ❑ YES ❑ NO *(Not to exceed **$**_____)*

$_____per pay X _____pay periods = $_____Annually

**** EMPLOYER MUST COMPLETE FOR MID YEAR ENROLLMENTS****

Date of 1st Deduction:	Eligibility Date:

DEPENDENT CARE ACCOUNT (DCA)

DAY CARE EXPENSES

I elect to participate. ❑ YES ❑ NO

*(Not to exceed **$5,000** or **$2,500** if married and filing separately.)*

$_____per pay X _____pay periods = $_____Annually

DIRECT DEPOSIT

PLEASE NOTE: NOT ALL EMPLOYERS ALLOW DIRECT DEPOSIT AS A REIMBURSEMENT OPTION.

Please check one:

❑ I elect NOT to participate in Direct Deposit.

❑ I elect to participate in Direct Deposit.

If you elected to participate in Direct Deposit, you will be responsible for logging into your Employee Portal and visiting your Profile to enter your **Banking** information.*

**New employees will be able to enter this information once login credentials have been issued. Current participating employees can request instructions from employer if needed.*

DEPENDENT INFORMATION			
FIRST NAME	**LAST NAME**	**DATE OF BIRTH** *MM/DD/YYYY*	**RELATIONSHIP** *SPOUSE, DOMESTIC PARTNER, CHILD, OTHER*

ACKNOWLEDGEMENT & SIGNATURE

☐ I acknowledge that I am authorizing the company to deduct equal amounts from my paychecks to collect the designated pre-tax amount above. I recognize that these selections constitute a deliberate binding decision on my part that may not be changed until the enrollment period for the next plan year or if I experience a change in status. I certify that I will only claim reimbursement for eligible expenses for myself and/or qualified dependents as defined in the SPD. I further certify that these expenses will not be reimbursed under any other benefit plan. I understand any unused dollars at the end of the plan year will be forfeited. I have examined the agreement and to the best of my knowledge, it is true, correct, and complete.

☐ Check this box if you are signing electronically to confirm that your electronic signature is the legal equivalent of your written signature.

Employee Signature:	Date: